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Contents:

CHILD PSYCHIATRY NUMBER

The Practical Application of Basic Mental Hygiene Principles by the Cornelian Corner. *By* Leo H. Bartemeier, M.D..... 113

A Commentary on the Oral Phase of Psychosexual Development. *By* Mary Leitch, M.D. 117

Some Considerations Regarding Psychotherapy with Psychotic Children. *By* Sibylle Escalona, Ph.D..... 127

Closed Institutions for Children? *By* Bruno Bettelheim, Ph.D.. 135

A Case of Anxiety Neurosis in a Small Child. *By* Nic Waal, M.D. 143

Book Notices 152

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BULLETIN of the
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THE PRACTICAL APPLICATION OF BASIC MENTAL HYGIENE PRINCIPLES BY THE CORNELIAN CORNER*

By LEO H. BARTEMEIER, M.D.†

Some time during the early months of 1942 two Detroit physicians, who regularly met each other for luncheon, began to engage in serious discussions about problems which had been concerning each of them for a rather long time. The pediatrician was preoccupied with the difficulties which so many mothers experienced in connection with the feeding and the care of their infants. It seemed to him that much of their anxiety and the obvious dissatisfactions of their infants were unnecessary and unnatural. In his effort to solve this problem he had broken with the traditional procedures and had advised the mothers to feed their infants as often as they seemed to want nourishment and to let them have as much as they would take. The results had been most gratifying. The mothers' anxieties diminished and the infants were appreciably more contented. This departure from the rigidity of feeding schedules was contrary, however, to what he had been taught and not in keeping with the practice of his colleagues.

The psychiatrist with whom he discussed this matter had been particularly concerned about the difficulties he had experienced in treating patients who suffered from severe mental disorders which often required long periods of hospitalization. He knew that their illnesses stemmed from intense dissatisfactions they had repeatedly suffered in their infancy and babyhood. He was intrigued with the contentment and satisfaction of both mothers and infants which the pediatrician had observed after he had allowed the infants to indicate how much and how often they should receive nourishment. In this radical break with traditional pediatric procedure the psychiatrist saw one possibility for improving the mother-child relationship and for lessening the incidence of the serious mental disorders of adult life. Like the pediatrician he was especially interested in preventive medicine.

These two physicians then began discussing their mutual interests with a few of their colleagues and learned that they too were concerned with the same problems. A small group, which included an obstetrician, an expert on nutrition, a registered nurse and a clinical psychologist, decided to continue and enlarge the original discussions between the psychiatrist and

* Approximately simultaneous publication here and in the *Journal of the Michigan State Medical Society* is by arrangement of the respective editors.

† Detroit, Michigan.

the pediatrician and to meet at regular intervals for the purpose of this collaboration. Accordingly, on November 12, 1942, they formed a small organization which they named the Cornelian Corner. The first Article of the Constitution which they framed at that time describes why they chose this name for their society. It reads as follows:

> "This association shall be named after Cornelia, daughter of Scipio Africanus, the Elder, mother of the Gracchi and of Sempronia, the wife of Scipio Africanus, the Younger. On the death of her husband, refusing numerous offers of marriage, she devoted herself to the education of her twelve children. When asked to show her jewels, she presented her sons, and on her death a statue was erected to her memory inscribed, 'Cornelia, the mother of the Gracchi'. The sons, Tiberius and Gaius, devoted their lives to the welfare of their fellow men.
>
> "When the kitchen was used by the family as a 'living room' it was customary for the mother to face a corner of the room when nursing her infant. Thus her back was turned to others in the room and both she and the infant were more removed from disturbing influences."

During the early meetings of this small group their discussions were confined in the main to the cultural influences which have effected a near disappearance of the nursing of infants and how this natural procedure might be re-established in the American scene. As their discussions continued, their objectives came to include all those early parental influences which determine so importantly the favorable or unfavorable evolution and development of character traits. They outlined these objectives in Article II of their constitution which reads as follows:

> "*Purpose.*—Believing that a program aimed at relief of the cultural tensions so frequently incident to feeding, toilet training, and child discipline represents the nuclear approach to the problem of mental hygiene, we dedicate ourselves to such a program.
>
> The purpose of this association, therefore, shall be to promote healthy parent-child relationships.
>
> We will strive toward the achievement of this objective:
>
> 1. Through research in the fields of child development and family life.
> 2. Through the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child.
> 3. Through the wide promulgation to professional groups of all pertinent information regarding the developing child and his environmental needs.
>   a) We will strongly advocate the abandonment of the artificial practice of separating the newborn child from his parents.
>   b) With the conviction that it is advantageous to both mother

and child, we will encourage the breast feeding of infants with opportunity to nurse whenever the infant is hungry or anxious."

During the five years that it has been in existence the Cornelian Corner has won the interest and the enthusiastic support of a surprisingly large number of people. For the past two years it has conducted seminars for physicians and for the nurses in charge of the pediatric and obstetrical wards in the general hospitals of metropolitan Detroit and the neighboring communities. These seminars have been made possible through a grant from the Children's Fund of Michigan. They have been conducted by leading pediatricians, psychiatrists, obstetricians and other specialists in the field of child development. In addition to this educational project, the Cornelian Corner has gained the cooperation of five Detroit hospitals in its project to have infants remain in the same room with their mothers from the time of their birth. This has already been carried out in a number of instances and some valuable data has been collected which already demonstrates the desirability for such procedures.

This brief history of the Cornelian Corner of Detroit constitutes a new development in preventive medicine and represents the first organized reaction to the most crucial human problem in our culture. This problem is reflected in the objectives of the Cornelian Corner. These objectives aim to re-establish the practices in infant care which were in vogue fifty years ago when babies were born in the home and mothers and fathers sensed the importance of satisfying their needs. Fifty years ago it was customary for mothers to nurse their babies, to feed them as often as they seemed to need nourishment, and to give them a great deal of mothering. Fathers commonly assisted in the care of their infants, and brothers and sisters had free access to the new baby almost from the time of its birth. These practices were wholesome and natural, but many mothers died in connection with childbirth and the percentage of infants who succumbed to infections was very large. It is a tribute to the progress of medical science that the number of maternal and infant deaths has been reduced to a minimum. The scientific discoveries which have protected the lives of so many mothers and infants have, however, eliminated many of the old fashioned practices connected with infant care. Physicians have concerned themselves with the strict enforcement of all procedures which insured the saving of human life. The personal care that mothers and fathers had previously bestowed on their newborn became the professional duty of hospital nurses and the isolation of the infant became an accepted procedure. Strict medical rules and regulations for the feeding and general care of the baby in the home replaced the natural ways in which parents of a former generation looked after their offspring.

The Cornelian Corner encourages the restoration of these folkways within the framework of present day medical procedures. The rationale for this new effort lies in the fact that the great discoveries of Freud have revealed that the old fashioned practices were psychologically sound and essential for the wholesome evolution and development of personality. These discoveries, which were derived from years of painstaking clinical investigations, have not only been confirmed by the researches of many other psychoanalysts but have gained general acceptance by psychiatrists and an increasing number of pediatricians.

These clinical investigations have repeatedly demonstrated that throughout the period of infancy and babyhood the entire existence of every child is dominated by two inherited strivings. One of these is the instinct of hunger and the other is the instinct for love and all that it implies at this period of development. Experiences which interfere with the gratification of either one of these instinctual strivings produce tension, discomfort and pain. The repeated occurrence of such states of tension gives rise to anxiety, to disturbances in digestion and to other interferences with the natural development of the child. Every infant, for example, in addition to the satisfaction of his hunger, also needs the gratification of his impulse to suck. No man-made schedules can adequately supply the satisfactions of these instinctual needs. They are inherited biological strivings which every good mother senses and knows how to satisfy. They vary in their intensity from one child to another—just as each infant even in the same family shows individual characteristics from the time of its birth. The need for a great deal of close proximity to his mother's body and all that we understand by the term mothering is just as important for the wholesome development of the infant as the need to be adequately fed. This natural mothering establishes the first human relationship which becomes the foundation for all other subsequent relationships and influences the character of the individual throughout his entire life.

The second objective of the Cornelian Corner is "the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child." The Cornelian Corner encourages the expectant father to accompany his wife on her first visit to the obstetrician and learn directly about her needs during the prenatal period so that he can share her experience with her and assist her to become a good mother.

Through its efforts to have the new-born infant in the same room with its mother from the time of birth the Cornelian Corner hopes to make it possible for the father of the child to visit as often as he can. It encourages him to hold his infant so that he, too, may begin to love his child as early as possible.

The Cornelian Corner is, therefore, a mental hygiene project which aims to promote better parent-child relationships from the very beginning of life.

A COMMENTARY ON THE ORAL PHASE OF PSYCHOSEXUAL DEVELOPMENT

By MARY LEITCH, M.D.

The object of this thesis is to describe the cases of several infants and to study them in the light of certain assumptions of psychoanalytic theory, principally those concerning the oral phase of psychosexual development. It will first be necessary to review very briefly the relevant psychoanalytic concepts as they appear in the literature. This will be followed by presentation and discussion of observational data.

Notes on the Literature

a.) *The oral phase—descriptive.* Abraham, who wrote extensively on this topic, stated that it was chiefly psychopathological material which compelled Freud and later himself to assume the existence of the phase in early infancy. This material and, apparently, a few unsystematic observations of infants led to the theory that the oral phase has two stages—an earlier one which is characterized by pleasurable sucking activity and a later one which is distinguished by the onset of pleasurable biting activities which replace in considerable part the pleasure in sucking. The gratification from the sucking and biting activities is considered a libidinal one.

b.) *The inter-action of constitutional and experiential factors in determining the amount of oral activity (suckling, thumb sucking and similar activities) in infancy.* Abraham and Freud indicated that suckling serves a double function, the infant obtaining nourishment and also experiencing satisfaction as a result of the stimulation of an erogenous zone, the mucous membranes of the lips.* This satisfaction or oral pleasure is further augmented by thumb sucking and similar activities. Both Abraham and Freud noted that there are individual variations in the degree of the tendency to suck for pleasure. These variations are, apparently, to be ascribed to the inter-action of experiential and constitutional factors.

Freud stated that the feeling of need in an erogenous zone can be awakened peripherally "through an actual change" in the zone.†

Abraham pointed out that some infants are permitted much more of the suckling activity by their mothers than are other infants. Anna Freud elaborates on this theme of the frustrations imposed by the environment

* Anna Freud designates the mucous membranes of the mouth as the erogenous zone in question, not limiting the sensitive area to the lips alone.

† The author interprets "actual change" to mean a temporary or permanent change in the physiology and/or structure of the zone resulting from injury, physical disease or contact with an external irritant.

and stresses the fact that a bad mother-child relationship may lead to refusal of nourishment.

Freud stated that it may be assumed that thumb sucking occurs only in children in whom the erogenous significance of the lip zone is "constitutionally reinforced". Unfortunately it is not known to what age of child he referred. Concerning infants in the first year of life, Anna Freud and Dorothy Burlingham state that thumb sucking occurs "profusely under all conditions," though its frequency and intensity varies from infant to infant. Anna Freud believes that thumb sucking plays an important part as a general comforter before sleep, when the child is lonely and dull, etc. If this is so, one would expect the amount of thumb sucking in any one infant to be determined not only by the strength of the constitutional factor, but also by conditions provoking dullness and other unpleasurable feelings in the infant.

Margaret Fries, on the basis of her work with infants, suggests that constitutional differences are partly responsible for the wide variations in the "activity patterns" (total amount of activity in twenty-four hours) of newborn infants and, apparently, these differences are reflected in the characteristics of the infants' suckling habits. The infant with a quiet "activity pattern" does not grasp the nipple so quickly as the more active infant and also can be distinguished from the latter by falling asleep during the nursing, remaining quiet or going to sleep when the nipple is removed, once it has just commenced to nurse well, and having to be urged to take the nipple again.

c.) *Fixation and regression.** Abraham pointed out that there are many ways in which development in the oral phase may suffer disturbance interfering with progression to the anal phase. As one source of disturbance in the sucking stage, he mentioned any quantitative divergence from the usual degree of pleasure gained. Whether the child had been indulged too much or too little, he believed the effect to be the same—difficulty for the child in taking leave of the sucking stage and fastening with particular intensity on the pleasures to be gotten from the next or biting stage.

Perhaps the most concise presentation of the causes of fixation and regression is that made by Fenichel. He points out that fixation and regression are complementary to one another and that the stronger the fixation the more readily will regression take place if difficulties arise. The most important factors responsible for evoking fixations are listed as 1) hereditary tendencies and 2) experiential factors, for example: excessive satisfactions

* In accordance with the definition of regression given by Freud[6] in "The Origin and Development of Psychoanalysis," the term regression is meant to indicate a return to an earlier phase of sexual life.

at a given level; excessive frustrations at a given level; abrupt changes from excessive satisfactions to excessive frustration.

d.) *Oral erotism as a source of character formation.* Abraham discussed the importance of oral erotism in character formation. He regarded the following as oral character traits—optimism or pessimism, impatient importunity, behaviorally always asking for something (moderate request or aggressive demand), impatience, voluble speech, ambition, haste, restlessness, envy, a morbidly intense appetite for food, etc. The concept has been elaborated on by Glover, Fenichel and others but does not need to be discussed further for the purposes of this paper.

Case Presentation and Discussion

If the above mentioned assumptions are valid, the author believes that it should eventually be possible to demonstrate in infants the following phenomena: 1) The existence of an oral phase in development and its division into two stages. One might expect to find not only progression from the earlier to the later stage, but also under certain circumstances, regression from the later to the earlier. 2) Variations between infants in the amount of oral activity. 3) The dependence of variations on constitutional as well as experiential factors. 4) Immediate effects—oral hypo-activity, hyperactivity or deviant activity—resulting from traumatic experiential factors. 5) The appearance as the child grows older of personality trends related to its oral experiences. Three cases will be presented with these points in mind. Possibly a few comments should be made about the method of case selection. The author reviewed the records of fifty consecutive cases of infants seen at the Menninger Clinic within the past year and one-half for developmental testing.* Those four cases showing the most clearly defined variations† from what might be considered an average amount of oral activity for the group were selected for special study in the light of psychoanalytic theory. Limitations of time and writing space necessitated omitting one case from this paper.

Case I. a.) *Data:* An illegitimate white male infant referred by a local social agency to determine the advisability of adoptive placement. The parents who were in their twenties were free from gross mental disorder. The mother had been known to have diabetes mellitus since the age of two. Her health during the pregnancy was good. The child was delivered in a local hospital by Caesarian section at full term. Immediate condition was good. In the hospital he contracted a severe case of thrush, and when he

* Most of these were the wards of a local social agency residing in boarding homes prior to adoptive placement.

† It is not implied that such variations constitute an abnormality in development.

entered a boarding home at the age of eleven days, he was still unable to nurse, so that it was necessary to give him milk by spoon. By six and one-half weeks of age when he was first seen by the agency pediatrician, the lesions were healing. Until they were well healed he slept most of the time.

When first seen at the Clinic at the age of 5.6 months he was considered a good eater, liking both bottle feedings and solid foods. He fussed when he had to wait for food. He was said to suck his thumb a great deal of the time and to do much bubble blowing. The boarding-home mother, a stable woman, had quite an indulgent attitude toward this. The psychologist noted that he was a fairly large, vigorous baby who was so preoccupied with thumb sucking that he did not have as much interest in exploring things about him as most infants his age. His first response to a stimulus was invariably to open his mouth. A good deal of bubble blowing, pursing the lips, etc. was noted. The total amount of oral activity was considerably in excess of that usually seen in infants his age. Formal testing (Cattell Infant Intelligence Scale and Gesell Developmental Schedules) showed that, while his developmental progress was not retarded, it had progressed somewhat unevenly, the scatter being more extensive than is ordinarily seen.

Seen again at the Clinic at 7.6 months, he was once more reported to have an excellent appetite. He was accepting feedings from the cup, seeming to prefer that to the bottle which he took only first thing in the morning and at bedtime. During the testing period there was again an unusual amount of oral activity. He brought everything to his mouth, biting and chewing on objects, his own hands, the hands of others and clothing. Formal test achievement was average for his age. The scatter was less extensive than before.

Following this test he was placed for adoption. As part of a research project he will be seen again after one year in his new home.

b.) *Discussion:* For over a month in very early infancy this child suffered from a painful condition of the mouth which made it impossible for him to suck. By 5.6 months of age it was noted clinically that sucking and other mouth activities were unusually important to him. While constitutional factors and the possibility of frustrating nursing experiences during the first few days of life prior to the mouth infection cannot be excluded, it seems reasonable to suppose that at least part of the excess oral activity was related to increased needs resulting from the early sense of frustration imposed by thrush and/or increased sensitivity of the oral zone related to actual changes in the mouth.

At five months the oral activity seen was predominantly of a sucking type; at 7.6 months the predominant activities were biting and chewing.

This progression from sucking to biting activity is in line with the theory concerning the division of the oral phase into two stages.

Oral activity appeared to be unusually important for this child, not only in the sucking stage but also in the biting stage. This persistence of an unusual degree of activity might be accounted for by Abraham's theory that disturbance in the sucking stage leads to excessive interest in the pleasures to be gotten from biting and/or, again, by actual changes in the mouth.

It remains to be seen what effect such early experiences will have on the character formation of this child. Other infants afflicted with thrush should be studied to determine whether oral hyperactivity invariably results.*

Case II. a.) *Data:* An illegitimate white female infant referred to the Clinic to determine advisability of adoptive placement. Concerning the father, little information was available. The mother was a twenty year old switchboard operator. Pregnancy was discovered early during medical examination following an automobile accident, but for six months the mother refused to believe that it was true. Delivery which occurred at full-term was uncomplicated. The baby's condition at birth was good. She was never breast fed. The mother stated that from the beginning she never cried at feeding time, never seemed to be hungry, was much slower in taking her bottle than were the other babies in the nursery but got mad when the bottle was taken away from her to burp her and grabbed it immediately when it was offered again. The mother was not disturbed over giving her up.

In the boarding home where she was placed at six weeks of age (the same home mentioned in Case I, but at an earlier date), the baby presented a definite problem. She slept most of the time. For about three weeks it took her forty-five minutes to take four ounces of milk, and she did not seem to care whether she finished it. (The bottle was offered at four hour intervals.) She no longer cried when the bottle was taken from her. Surprisingly enough, she remained rather well nourished.

Although the feeding habits improved so that when first seen at the Clinic at three months, she was taking eight ounces of milk in twenty-five minutes, she still showed comparatively little interest in her bottle, not infrequently falling asleep during the feeding. She refused bottles altogether unless the hole in the nipple was enlarged. On the other hand, she accepted spoon feedings with pleasure. She showed little interest in sucking her thumb or other objects. The psychologist described her as a small but well formed, exceptionally attractive baby. She was moderately active; social responsiveness was good. Responsiveness to objects, though usually delayed and

* It might be possible that extremely severe infection causing tissue destruction might result in lessened sensitivity in the oral zone and oral hypoactivity.

at times very brief, was adequate. She showed a special readiness to become fatigued. The formal test findings indicated some unevenness of development in a baby of at least good average endowment.

Seen again at five months, the baby's boarding home mother reported considerable improvement in her behavior. She was taking five ounces of milk in fifteen minutes from a nipple with a small hole. She fussed at bottle time and kept one hand on the bottle while nursing. When her bib was put on she kicked and looked pleased. She cried when the bottle was taken from her to burp her and when it was offered again, opened her mouth and tried to grab it back. There was a moderate amount of thumb sucking. On the tests, development now appeared to be slightly accelerated. Unevenness was less marked.

Not long after the second testing of the child at five months, adoptive placement was made in an urban middle-class family where there was one other adopted child, a boy a year older than herself. The adoptive mother gave the impression of being a loving but rather rigid person who dealt strictly with her children.

When eighteen months of age, the child was brought back for a research retest. At this time the adoptive mother stated that after adoption the child, while sucking on her bottle or thumb, had pulled at her hair so vigorously as to pull it out. Being unable to break her of this hair-pulling habit and finally considering it "too much of a good thing", the mother weaned her abruptly at eleven months and also painted her thumbs at bedtime with a bitter tasting patented "cure". After a few nights of crying, the thumb sucking was given up entirely. She did not seem to object to the weaning; however, since then she has been indifferent to or rejecting milk and has eaten excessive quantities of other foods. She was toilet-trained very easily at twelve months. For awhile when angry, she would throw herself on the floor. Spanking put an end to this behavior, but she then began to express her anger by biting not only others but also herself. One of the first words she spoke was "bite", which was her term for eating. In the testing situation, she showed herself as a plump, moderately happy child who was, however, very impatient and unusually insistent in her demands for toys. After playing with one toy for a minute or two, she would reach toward the toy box with outstretched arms, saying "more, more". Intellectual functioning was good average.

b.) *Discussion:* During the first three months of life, this child showed exceptionally puzzling behavior. On the one hand, she did little thumb sucking, did not suck well at the nipple and seemed to have a poor appetite for milk. On the other hand, she seemed to derive considerable pleasure from solid food which she accepted readily. While with her own mother, despite her apparent lack of hunger and lack of interest in sucking, she

became angry when the bottle was taken away from her in order to burp her. After separation from her mother at six weeks, she no longer objected to the bottle being taken. The author knows of no theory which would adequately and reliably explain the total picture. Concerning specific aspects of the behavior described, a number of possible explanations present themselves. 1) That the report from the child's own mother and/or boarding home mother were inaccurate. While there is considerable doubt as to the reliability of the mother's observations, the boarding home mother is considered by the agency and by the psychologist to be a reliable and reasonably good observer. 2) That the constitutionally determined sensitivity of the lip zone was unusually low, hence the child was little interested in sucking. In connection with this, it should be pointed out that the mucous membrane of the rest of the mouth seemed to be quite sensitive, for the child, apparently, was capable of deriving considerable oral satisfaction from the taste and consistency of solid food. Possibly the degree of sensitivity varies in different areas in any one erogenous zone. 3) That a bad mother-child relationship resulted in very early frustrating nursing experiences with a consequent lack of interest in sucking and a poor appetite for milk. The mother's refusal to admit the pregnancy, the fact that she made no attempt to nurse the child and her lack of concern over giving the child up would suggest that her attitude was far from desirable. 4) That the sucking reflex was grossly underdeveloped at birth, hence the child was physically unable to suck well. This may have been so, but there were no other signs suggestive of an unusual degree of immaturity of the central nervous system. At the same time, as the child was unable (or not desirous) to suck well, she was rather expert in swallowing. Regarding the gradual increase in interest in sucking with increased age, one can speculate that development of the sucking reflex and/or a good boarding home mother-child relationship were responsible. The author believes that from this discussion of the child's early life, two conclusions may be drawn—that some factor, the nature of which is not understood, interfered with sucking and that the child received comparatively little oral pleasure.

Passing on to the later stages of the child's development, the data show that the good relationship with the boarding home mother was followed by life with a loving but rather rigid adoptive mother who suddenly deprived the child of several of her customary sources of oral pleasure (bottle feedings and thumb sucking). The child continued to get oral satisfaction by eating excessive quantities of food, but that the weaning was traumatic can be surmised from her rejection of milk. Possibly, in accordance with psychoanalytic assumptions, the impatience, demandingness, etc. noticed at eighteen months might be considered as personality trends resulting from frustrating oral experiences. Likewise, the child's biting herself might be

considered a regressive phenomenon. However, the author does not believe that these conclusions can be drawn until a study of the possible occurrence of the same personality trends under different conditions has been made and the frequency of such biting behavior at the eighteen months age level has been established.

Case III. a.) *Data:* A legitimate white boy baby seen on a research basis at 2.3, 4.2, 5.6, 6.9, 7.7, 9.5 and 10.6 months. The father was a business man. Both parents were free from physical and mental disorder. Pregnancy was normal. Delivery was uncomplicated. The baby's condition at birth was good. From ten days to eight weeks of age he had severe colic which cleared up after ten days of luminal medication. He was breast-fed on a schedule indulgent enough that it might almost be considered a self-demand one. Bottle feedings were occasionally given after the 4th month so that he would be less apt to experience difficulty with them when the mother happened to go out for an evening. No attempts at toilet-training were made.

Repeated testing showed normal developmental progress. He was a very responsive, observant child. At 4.2 months the mother reported that he did some bubble blowing when excited. At 6.9 months he was reported to have a large food intake and to like to smear food all over. In the testing situation, oral activity (sucking, reaching for things with his mouth) was now marked. Immunization had been started and he would cry as soon as he saw the doctor. By 7.7 months he was no longer enthusiastic about the bottle, liking to take milk from a cup, and he had started to bite things. Clinically, he brought many objects to his mouth, but no other type of oral activity was seen. At 9.5 months the mother reported that he had become more discriminating about food. He would playfully bite people and pull their hair.

Five days prior to the testing at 10.6 months he was vaccinated for smallpox and had a severe local reaction with high fever. His mother noted that along with this, his behavior changed markedly. The bottle was again very important to him. He became finicky and fussy about solid foods, refusing many of them. He whined a lot and cried easily. Demands on the mother were more intense and he could tolerate no delay. At bedtime he screamed despite being soothed and given a bottle. Most remarkable of all was that the biting behavior so prominent before, disappeared entirely and he either sucked objects or held them in his mouth without chewing them. Clinically, no biting activity was seen. A followup report indicated that it started again several days after the test as the local swelling, etc., of the arm subsided.

b.) *Discussion:* Following severe local and systemic reactions to smallpox vaccination, this child gave up biting which was important to him at the time in favor of his former pleasurable sucking activity, i.e. he regressed

from the oral biting to the oral sucking stage of development. One might speculate that the comparatively indulgent feeding schedule resulted in his getting an unusual amount of satisfaction during the sucking stage and that this, in turn, resulted in fixation at this stage and greater vulnerability to regression. On the other hand, the weakness or immaturity of the ego organization at this early age might likewise predispose to regression.

The data show both progression from a sucking to a biting stage, and regression from a biting to a sucking stage. Thus, in two ways, the division of the oral phase into two stages is demonstrated.

Summary and Conclusions

Three cases of infants have been presented and discussed. It is believed that the data tend to support psychoanalytic assumptions concerning the existence of an oral phase in development, the division of the phase into two stages, variations between infants in the amount of oral activity, and the dependence of these variations on factors of various types. However, it is clear that more detailed and systematic studies are needed to verify the assumptions and to clarify the factors responsible for differences in the oral behavior of infants. Unfortunately, little is yet known about the range and variability of infant behavior, and the relationship between specific modes of behavior and specific constitutional, physical and environmental conditions.

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SOME CONSIDERATIONS REGARDING PSYCHOTHERAPY WITH PSYCHOTIC CHILDREN

By SIBYLLE ESCALONA, Ph.D.*

When a relatively new group of clinical phenomena become prominent in his experience, the clinician is impelled to review the extent of his knowledge in the area in question. The following comments are the result of such a re-evaluation of some of the assumptions which underlie much of our psychotherapeutic work with severely disorganized children. No striking successes will be reported, nor new treatment ideas advanced. The aim is merely to integrate certain clinical observations with established modes of thinking in the field of psychotherapy generally. The only conclusions that may be anticipated, therefore, are a series of question marks.

Our thinking about treatment and the goals of therapy is largely determined by our convictions regarding the etiology and nature of the condition to be treated. Hence, it will be necessary to briefly describe the type of illness here to be referred to as "psychosis of childhood." The very term, psychosis of childhood, is disapproved by many who feel that no maladjustment in childhood can be so diagnosed in the absence of certain classical signs and symptoms which serve as criteria for a diagnosis of psychosis in maturity. Whatever term one decides to use—and childhood psychosis may be taken as an abbreviation for "grossly atypical development" or for "severe disintegration of personality"—we have an only too vivid mental picture of the type of child to whom these and similar terms are applied. Several varieties of (in this sense) psychotic children have been described in the literature within recent years. Among the better known publications are those by Kanner[5,6,7], Bender[1,2], Bradley[3], and Schumacher[8]. In spite of the semantic confusion in this area, certain descriptive criteria have emerged which characterize the various disorders of childhood which may be grouped together under the heading of childhood psychosis.

During the last 4 years, 17 children between the ages of 5 and 16 years were diagnosed as suffering from a psychosis of childhood by the Children's Division of The Menninger Clinic. All of these children were free from organic pathology within the limits of validity set by clinical neurological and physical examinations including routine laboratory work, EEG, and skull x-ray. Upon survey of the entire group of cases, the following characteristics seem outstanding:

(1) Wherever an adequate early history could be obtained it was noted

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that the development of these severely disturbed children has been atypical and irregular since earliest infancy. The deviant development need not be in the direction of retardation; in some instances there was a precocity of development in certain areas and retardation in others. (Some of these children, for instance, walked early and showed generally advanced neuromuscular development and motor control but were seriously retarded in speech or some other area). Also, not infrequently, certain developmental achievements were gained at an approximately normal time but were lost again or else developmental progress in a certain sphere was arrested at a given point whereas in other areas this was not the case. For instance, several of the children learned to speak quite early only to lapse into prolonged periods of mutism later on. One learned to walk at 13 months but returned to more primitive modes of locomotion during the second year of life and had to learn to walk upright all over again. Mental functioning, in as much as this could be ascertained at the time of examination, varied from a generally retarded level to very superior intelligence functioning, but in all cases it appeared to be uneven with spot-like areas of accomplishment way above and way below what would appear to be the basic or most representative level of mental functioning for the particular child.*

(2) Wherever the life histories of severely disorganized children were given adequate scrutiny, it was noted that disturbances in the earliest and most basic interpersonal relationships were present. Early feeding difficulties, resistance to weaning, traumatic toilet training, difficulties over physical restraint, sleeping disturbances—all the familiar landmarks of infantile maladjustment—cropped up with monotonous regularity. Furthermore, most of the mothers or other persons in close contact with these children, spontaneously commented that there was something puzzling and "different" about these children from a very early age on. Mothers felt that they never knew what to expect, that they lacked a sense of intimacy and close rapport which they had known with their other children. One gains the impression that either remoteness or an exceptionally high degree of irritability (or both) in the child prevented a close inter-dependent relationship between mother and child in many of these instances.

This is one of the points at which we wish to call attention to a possible source of error in our thinking about the nature of this illness and hence about the appropriate therapeutic approach. From experience with non-psychotic children it is well known that behavior deviations of the kind just enumerated are often produced by parental attitudes. Hence, it is easy to

* This is more or less a matter of definition since children who show other psychotic-like features but give the characteristic picture of essential feeblemindedness (to psychological testing) are grouped under a different diagnostic category, namely, "mental deficiency and psychosis."

assume that in these severely disturbed children, maternal rejection is at the root of the trouble. Yet, the more one studies the early life history of psychotic children, the more one is impressed with the atypical and pathological reaction of the children to perfectly ordinary maternal attitudes and to the inevitable daily routines. A baby who will not eat when food is offered, who cries when he is expected to sleep, who is incessantly active or pathologically lethargic, who reacts with panicky resistance to routine procedures such as bathing or being dressed, and who rarely provides for the mother the emotional gratification that comes from having the baby respond to her positively cannot help but be upsetting to even the most loving mother. Finding the usual methods of baby care unsuccessful with their atypical children, these mothers will, of course, "try everything" and thus go to extremes in both strictness and indulgence. They will seek and receive contradictory advice and act upon much of it, and when we come along to take a developmental history it is found that the child has been managed inconsistently. After years of more or less unsuccessful attempts to manage the child effectively, feelings of ambivalence and guilt must of necessity develop in mothers of such children, and the presence of such maternal attitudes is apt to lead the therapist to think of the disturbed mother-child relationship as the cause of the child's illness. It seems possible to the writer that we may sometimes be confusing end-results with causes. Therapeutic programs might at times be modified if these early developmental disturbances were regarded as arising in large measure from the pathology within the child rather than from parental attitudes per se. With this assumption the disturbed mother-child relationship will still be regarded as an important etiological factor in that it creates an unfavorable psychological atmosphere in the home, but will be viewed as a by-product of the total maladjustment picture.

(3) Turning from characteristic features of the developmental history in cases of childhood psychosis to the condition as seen when such children are brought to the attention of psychiatrists and psychologists, one may say that they present a large variety of behavior pictures which in all cases lead to a generalized and far-reaching inadequacy on the part of the child. This inadequacy, whatever form it took, made it impossible for these children to cope with whatever life situations are ordinarily appropriate at a given age and under given environmental circumstances. More specifically, the following phenomena were frequently encountered:

(a) Speech disorders, ranging from near mutism to peculiar, bizarre, deviantly structured speech often including neologisms.

(b) Deviant thought processes including circular and autistic logic. The peculiar type of reasoning encountered among these children is most readily discernible on a battery of psychological tests but is also apparent in clinical

examination if an effort is made to investigate this area of mental functioning.

(c) Bizarre preoccupations and unusual interests which may or may not be accompanied by special ability in the area of preoccupation. Among these children we have often seen a peculiar fascination with machinery (sometimes narrowed down to one type, such as fans or telephones); one child was interested principally in skin, and thought content as well as fantasies centered on differences between various kinds of skin, etc; one child was obsessed with spatial relationships such as inside-outside, upside-down, etc., and some children focused their interest, almost to the exclusion of anything else, on oddly selected topics such as magic, frogs, circuses, marine life, etc.

(d) All of these children showed extraordinarily low frustration tolerance, amounting to a kind of hyper-sensitivity, which experiences any delay or impediment, however small, as intense frustration and may lead to rage reactions or autistic withdrawal.

(e) Characteristically these children showed excessive fantasying of an irrealistic kind which permits conscious awareness and open expression of material which ordinarily remains unconscious, and which can be elicited from neurotic or normal children only with difficulty.* Often these children showed a genuine inability to distinguish between fantasy and real experience, leading to glaring misinterpretations of reality situations and occasionally to definitely crystallized delusions.

(f) Learning ability may be intact, but fail to function in normal school situations because of the child's inability to maintain social relationships and accept restriction. (Some of our patients expelled from school as feebleminded made up the work equivalent to several grades in one year of private tutoring.) On the other hand, there may be learning disabilities seemingly arising from a lack of integrative capacity and a lack of motivation rather than from a lack of ability.

If this descriptive summary is representative, what are the implications for appropriate treatment programs? It goes without saying that in cases of this type, as well as in any therapeutic work with children, treatment programs must be a total educative effort whether it includes 24 hour planning in an institution or whether it includes guidance of the family in planning for the child. The issues we wish to discuss here, however, have to do with what goes on in the therapeutic sessions.

On the basis of clinical experience with the more usual types of psychiatric disorders in childhood our general approach may be described as follows:

* We have been impressed with the predominance of cannibalistic fantasies, but, of course, all other types of fantasies may also occur.

we assume that what has been done to a human being can be undone. Thus we believe that if a maladjusted child can experience—in his relation to the therapist—some of the gratifications and the sense of continuity and stability which he lacked in his earlier life; if he can be helped to remember and understand events which were traumatic to him; and if his misconceptions about human affairs can be interpreted in terms of his needs—then normal processes of ego development can be resumed, and the object of psychotherapy will have been achieved. Therapeutic endeavours, therefore, are directed at permitting the expression of previously unconscious material, fantasies are seen as meaningful and interpreted in the context of the child's reality experiences, and the relationship between affects and their source, as well as between symptoms and their deeper meaning, is explored.

Endless hours have been spent by qualified therapists in treating psychotic children on the basis of these axioms, often with discouraging results. It has occurred to us that, although the symptoms of these children are just as meaningful psychologically, and as amenable to interpretation, as is the case with neurotic children, the immediate aim (and possibly the ultimate aim) of psychotherapy with psychotic children might be almost the opposite from the one we are accustomed to using with neurotic children. If the type of therapy just described may be referred to as *expressive*, the alternate type might be called *suppressive*. Suppressive psychotherapy proceeds from a recognition of the fact that psychotic children, by definition as it were, show extreme weakness in ego functioning and at times a disintegrative process appears to interfere with ego development. Hence, these children have failed to repress psychic experience which normally should be unconscious so that their spontaneous verbalization of conscious content resembles the dreams of other children; and the play of psychotic children during initial interviews is often much like the play material obtained from neurotic children who have been in therapy for many months. If the ego is judged to be too weak to assimilate and reconcile the impulses, needs and conflicts actually present, it is conceivable to plan in the direction of protecting the ego from the impact of instinctual forces. Thus therapy would be directed at discouraging the expression and acting out of fantasies, and providing as much gratification as possible in more realistic pursuits, and at strengthening reality testing by all possible means. Both suppressive and expressive psychotherapy have in common, of course, that they work primarily through the relationship between child and therapist. (In suppressive therapy, however, the relationship itself would rarely become the subject of analysis. In fact, as far as we can see, this type of psychotherapeutic relationship with a child is possible only if a positive transference can be maintained).*

* Technically this can often be accomplished by limiting transference interpreta-

As one follows the progress of a series of psychotic children in treatment of either of these two varieties, one cannot help receiving the impression that neither approach is entirely successful in the sense of bringing about improvement which will be maintained after cessation of treatment. In the following we shall briefly summarize the characteristic responses of psychotic children to the two types of treatment under the conditions prevailing at our Clinic:

Given a sufficiently long time in which to do so, the psychotic children of whom we know, all were able to form a strong dependent relationship with their therapist. In fact some became so dependent that a therapist's absence, for any reason, or a change in therapists were major traumatic events causing serious sudden relapses into modes of behavior characteristic of the child during earlier phases of the illness.

The children who received what we have called an expressive type of psychotherapy have demonstrated, on occasion, an almost uncanny ability to understand their own behavior, even offering spontaneous interpretations which as far as could be ascertained were keen and accurate statements of fact. For instance, one 7 year old girl, suffering from a life-long maladjustment, judged to be of psychotic degree at age 6, who later developed a clear schizophrenic syndrome, was able to work through her very severe eating difficulties in treatment. Through the verbalization of fantasies and dreams, and endless hours of role play, she became convinced that food is not fecal matter and resumed eating in satisfactory amounts. However, in spite of a strong attachment to the therapist, and although the content of therapeutic sessions was by no means limited to this topic, her general behavior remained relatively unaltered. Fearfulness, infantile speech and motor patterns, periods of inexplicable excitement, excessive openly expressed fantasies of a bizarre nature—and other overtly psychotic features continued to be present.

Another child, a schizophrenic boy whose treatment began during his 10th year and who at age 12 showed definite signs of deterioration, surprised us not only by his extreme dependence upon the therapist (he used to say in a manner far from bland, "You have to be here so I can be happy"), but by flashes of rare insight. This withdrawn, deluded child, who gave the appearance of feeblemindedness and was out of contact with his environment much of the time, said on one occasion when he discussed the reasons for his institutionalization with the therapist, "Nobody can really help me. I don't like anybody, not even my mother. Doctor —— (mentioning his previous therapist) liked me and tried to help me, and you like me but you

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tions to rather superficial ones on negative aspects of the transference. Positive transference phenomena are then accepted at face value and thus maintained.

can't help me. I don't love anyone, I want to kill everybody." Immediately afterwards he lapsed into rambling incoherent talk centering on one of his longstanding preoccupations and never mentioned the matter again. It is of interest that the matter of this child's capacity for affection had not been mentioned to him previously. This boy, like several others, aroused deceptive hopes in his therapist by apparent good clinical improvement contingent upon daily contact with the therapist. He gave up much of his fantasy life, or at least no longer expressed it openly, he resumed school work, and entered into friendly contacts with children and adults—all accomplishments of which he had been thought incapable. The important point here is, however, that a short separation from the therapist caused a complete relapse, and that he at no time developed even a minimum of tolerance for any frustration whatsoever.

These examples are meant to be representative of a good many more, and tend to show that even overtly psychotic children are capable of developing a meaningful relationship to a therapist, of showing temporary clinical improvement due to such a relationship, and of verbalizing and affectively experiencing insight. Yet (with one possible exception) in our experience such improvements are not maintained, nor does treatment set in motion the autonomous functions of growth and development as it does in neurotic children. It is as though, to use an analogy, psychotic children could be held above water by the therapist's support, whereas non-psychotic children can be taught to swim by their own efforts.

The response of psychotic children to a suppressive type of psychotherapy, as far as we have been able to observe, has been somewhat different but not necessarily more encouraging. In the case of the little girl mentioned previously, for instance, the type of therapy was changed after one year, in view of the fact that while a specific symptom disappeared, her total development seemed to continue in its pathological course. She saw another therapist, the same number of hours per week, for several years. After initial difficulty in connection with the change in therapists she developed an equally intensive relationship with the new person, but the content of the sessions although they still took the form of play, changed to an emphasis on the immediate reality situation. This girl, gradually, showed marked clinical improvement in that she lost her infantile mannerisms, became able to associate with her peers, accomplished school work in keeping with standards for her age (though this was done by private tutoring), and hardly ever spoke in the excited, irrational manner previously characteristic of her. However, psychological tests as well as psychiatric interviews of the usual permissive type, showed that the psychotic process continued undiminished. The bizarre fantasies could easily be elicited though they were no longer volunteered, thought patterns continued autis-

tic and schizophrenic-like, and her capacity for genuine affective rapport continued very poor—although she went through the motions of ordinary social interaction.

A very similar series of changes was noted in a boy, age 8, when treatment was initiated, in whose case therapy was of the suppressive type to begin with and went on for a number of years. At age 8 he was flighty, rambling and incoherent in speech, expressed bizarre ideas, had many fears, was unable to relate himself to anyone, lost bowel and bladder control whenever excited, and generally presented the picture of a totally deviant inadequate child. Very gradually, almost all of the overtly striking symptoms disappeared. His speech, when listened to closely, was still rambling and disjointed. Since the content had become innocuous where it used to be bizarre, however, this was rarely noted by the casual observer. Disturbances in elimination control had been overcome, as had most of his fears, and his violent aggressive outbursts were replaced by generalized mischievousness. So favorable an impression did this child make after some years of treatment that placement in a school for normal children was considered. Yet here again re-examination showed that the illness had merely gone underground, so to speak, and actually had reached a more advanced stage. Neither rational thought nor adequate reality testing were possible for him, a positive attachment to people was lacking, and the most extraordinary fantasies could readily be elicited—they were merely held in check.

These examples of observations, chosen from a somewhat larger group, if verified by the clinical experience of others, suggest certain cautions and problems for further investigation in regard to the treatment of psychotic children. The following summarizing statements are offered very tentatively as a basis for further discussion and in no sense as conclusions:

1. Illness of psychotic degree occurring in early childhood, is associated with severe developmental irregularities beginning at earliest infancy, as well as with profound disturbances in the relationship between the child and his parents. It is suggested that maternal feelings of ambivalence, guilt, etc., and the resultant inconsistent and apparently punitive management of the child, may often arise in consequence of the child's atypical behavior. Therefore, it cannot be assumed that the child's illness was largely caused by an unfavorable psychological milieu.

2. Two principally different therapeutic approaches to the psychotic child have been mentioned, both of which are consistent with established psychodynamic concepts of personality development and psychopathology. Both expressive and suppressive psychotherapy, provided they are maintained for a long time and embedded in an adequate total treatment program, have resulted in clinical improvement in some instances. The main

difference in the response of psychotic children to these two modes of treatment appear to be that expressive therapy may work through and really "cure" specific symptoms. It may also bring about temporary all-over improvement which, however, is not maintained. The functioning of the entire personality, however, is not altered significantly.

Suppressive psychotherapy may bring about clinical improvement, principally in the direction of increased controls and conformity. The underlying psychotic process remains untouched, however, limiting the most favorable outcome of such therapy to a pseudo-adjustment on the part of the child.

3. The response of psychotic children to therapy is often such as would justify an optimistic prognosis in neurotic children. In severely disturbed children under our observation, the occurrence of insight, development of a transference situation, and clinical improvement in direct response to therapeutic work, all were present, yet the treatment failed to result in ultimate improvement. This suggests that criteria by which the success of treatment is measured may have to be modified in regard to psychotic children.

4. Adequate therapeutic measures, in cases of childhood psychosis, can be developed—if at all—only if the nature and causes of these conditions can be understood much more fully than they are at present.

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CLOSED INSTITUTIONS FOR CHILDREN?*

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The number of residential institutions which specialize in the treatment of emotionally disturbed children is very small. Therefore, when a child is in need of placement in such an institution the planning has to be based on the facilities available rather than on the structure of the child's disturbance and on whether the physical setting and human environment is truly most suitable for supporting his treatment and ensuring its success. Moreover, many of the existing institutions, particularly those supposedly serving delinquent children, and also many orphanages, are so ineffectual, that most discussions of the residential treatment of children reduce themselves mainly to criticism.

Because of this failure, the prevalent tendency for some time was away from all residential institutions. The contention was that a good home is a better place for a child than an institution. Here, there is little room for disagreement. But what constitutes a good home for a particular child, and particularly for a seriously disturbed child? Good homes are scarce, and even homes which are good by average standards, may not be so good for the particular needs of the emotionally disturbed child. Even the best intentioned foster parents are often in no position to accept without inner criticism the acting-out behavior of some disturbed children, while other relatively good foster parents cannot continue to offer emotional gratification in the face of continuous rejection by negative, depressive, or utterly withdrawn children. Still other foster parents feel unable, despite initial good will, to continue to take the rejection and criticism of their neighbors because they permit a child to continue his asocial behavior.

In view of the re-awakening interest in residential treatment homes for emotionally disturbed children, and despite the large number of children in need of placement, the scarcity of theoretical discussion concerning itself with the characteristics of good treatment homes for children is astonishing. Even when their problems are occasionally discussed, the argument is often too generalized, as if what might be a desirable setting for one type of emotionally disturbed child would also be good for all others. In the absence of clear ideas on the problems confronting administrators of such homes and of the factors which make a particular setting therapeutic for particular children, situations arise in which even justly famous institutions

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base their admission policy on the presenting symptom rather than on the structure of the child's problem, its etiology, and probable evolution during treatment.

Thus it would seem that the future development of more adequate and, one might add, more specialized, institutions for disturbed children will to a large degree depend on a differential analysis of which particular combination of institutional characteristics make a setting most appropriate for children suffering from a particular type of disturbance.

It may be assumed that the institutions here under discussion will serve only children of normal intelligence, or of potentially normal intelligence, and only children who are free of organic disease, be it physical handicap, or non-functional emotional disturbance. Since most available data are those on institutions for delinquents or children who are so characterized, and since the discussion of treatment homes based on psychoanalytical principles originated with Aichhorn's experience with delinquents, this discussion is weighted with their problems. But much that is true for this group is also true in a general way for other groups of emotionally disturbed children.

In reaction to the abuses to which many delinquents were and still are exposed in some of the existing closed institutions, the general consensus seems to have formed that they are best placed in open institutions, preferably those in open country so as to avoid all restrictions on motor discharge or unconventional behavior which may originate in demands of the adjacent communities. To what degree such recommendations are guided by the desire to hide the children away, or by the conviction that trees, and chicks and pigs are more therapeutic than interpersonal relationships, is a question I do not intend to pursue. Suffice it to say that it is quite unlikely, in a place far from the centers of intellectual, social and esthetic stimulation and gratification, that the type of staff (including competent child psychiatrists) can be assembled, who in private life enjoy the emotional gratification which alone permits them to give gratification again and again to children whose behavior is often annoying if not exasperating and who can do so without expecting emotional returns from the youngsters to whom they devote themselves. Another consideration must be that it is not sufficient to adjust to relatively "simple" country life, children who grew up in, and will return to, an urban center, and for whom the temptations they could not withstand originated in the seduction of city life. While the elimination of urban dangers may be an important device at some time during the treatment period, there is little doubt that a sudden return from the relatively protective country setting to the excitement of city life may destroy a newly acquired and as yet untested integration. Thus even the location of a treatment home for delinquent children poses difficult questions: while

seclusion and protection from temptation may be therapeutically indicated at one time during the treatment, there are other times when their slow and carefully dosed introduction to it seems equally needed.

One of the major problems confronting those who plan institutional treatment settings for emotionally disturbed children is that of combining relative freedom with necessary protection, without the use of undue restraint. Few of the existing closed institutions seem to have solved this problem, but rather to have circumvented it—frequently by exercising unwarranted restraint in the name of "necessary protection".

Many open institutions, on the other hand, are so in name only: the absence of bars on the windows and of a locked gate does not make for an open institution if, within the institutional setting, the life of the child is strictly regulated by withdrawals of privileges, or if a runaway child is brought back by force, and against his will. Conversely, there are open institutions which claim such freedom from limitations, that one cannot help wondering how they mange to provide the security to which an emotionally disturbed child is entitled. Most institutions, both open and closed, claim to permit the children much greater freedom than they actually enjoy, thus revealing either the incompetence or bad conscience of institutional administrators, or their desire to make a "good" impression on laymen.

Most of the existing closed institutions, particularly those for delinquents, are based on the idea of locking them up safely, so that they will be unable to commit further acts of delinquency. Often this restraint is rationalized as a means of preventing further exposure to temptation. Unfortunately, the notion of protective restraint—which could be defended on theoretical grounds—is too often entangled with the idea of punishment through restraint. Also, whether or not a youngster is sent to a closed institution usually depends on the presenting symptom: if it is sufficiently annoying to the community he is put away, regardless of whether greater freedom or restraint is therapeutically indicated. In this way, punitive tendencies in the existing closed institutions take precedence over the idea of therapeutically indicated restraint and protection, and the so-called reform school usually achieves results which belie its name. But these shortcomings should not lead us to do away altogether with any semblance of restraint when dealing with delinquent children; there is a real need for good closed therapeutic institutions for children although none are as yet in existence.

Ideally, both open and closed institutions should provide experiences which are as gratifying and as therapeutic as possible. Their difference should consist only in the fact that the closed institution should prevent the child's exposure to tempting experiences, be it seduction to stealing

(which for some children is inherent in seemingly unsupervised stores), the stimulation of hostile and anxious fantasies through comics or movies, or the fear that through pure chance they may meet former associates, or parents. The open institution, on the other hand, should provide an equally protective environment, but one from which the child can venture at his good leisure into the more tempting, but also more dangerous outer world. While the closed institution should provide stimulation and experience for the child in accordance with his therapeutic needs, and the tools of mastery at his disposal, the open institution should offer the child some degree of self-dosage with such experiences.

Both institutions, as a matter of course, must offer the child full gratification of his physiological, emotional, and intellectual needs. He must be permitted to satisfy, for example, his desire for both rest and motility. For the closed institutions this implies provision of a much greater variety of opportunities for motor discharge through more spacious grounds and more elaborate play equipment than in the open institution, since in the latter the child can add from the outside world to what the institution provides. The same is true for intellectual stimulation: the closed institution must offer more, although with greater planning as regards the child's desire and ability to enjoy this stimulation, while the open institution can rely on some intellectual stimulation from the outside world. The same is true, *mutatis mutandi*, for the factor which makes these institutions therapeutic: interpersonal relationships.

The attitude of the closed institution must be one of protecting the child against the pernicious influence of the outside world when necessary (including that of his parents), and never of protecting the outside world from the inmate of the institution. Because of the restrictions which living in a closed institution implies, it must go even further than the open institution in providing all possible gratification: offering ample, good and healthy food, for example, is not enough unless through the conditions surrounding it, it also provides ample oral gratification. Courses which must be eaten in a particular sequence and only at a particular time only rarely provide full oral gratification. A relatively large degree of autonomy in schedule, quantity and selection of fare, must always be possible. This is particularly important in a closed institution which imposes relatively greater restrictions in other ways. Since the closed institution precludes total planning of his activities by the child, his own activity within the institution must proceed even more autonomously than in the open institution. Again, because the closed institution confines him, explanation of all the details of the running of the institution is absolutely necessary, and he must be given a voice in arranging life within the institution.

In planning differential treatment for disturbed children, under what

circumstances should we consider placement in a closed institution to be preferable to that in an open institution?

Experiences at the Orthogenic School—an open institution—have demonstrated that in many cases the problem of placing a child in an open or closed institution is not usually an "either or" proposition. A particular type of neurotic delinquent child, for example, would profit most from combined treatment in an open and a closed therapeutic institution. Strange as it may seem, and contrary to prevailing practice, the child showing the most severe delinquent behavior is frequently the one who at first needs temporary placement in an open institution, and will profit from placement in a closed institution only after he has shown marked improvement in his ability to integrate. Later, in the final stage of reintroduction to the community, it often seems desirable to return him to an open institution. The need for this three-step process becomes understandable when we think of an aggressive and destructive child subject to violent temper outbursts when he experiences even unavoidable frustrations. The closed institution deprives such a child of the necessary discharge of aggressive tendencies through motility, by running away—nor does it permit him to instantly leave the presence of the person against whom his anger is directed, so that he is unable to protect himself by running away from the danger of doing violence to that person.

Once this youngster has learned some degree of mastery over his aggressive tendencies and is ready to acquire some ability to withstand frustrations, the open institution falls short of his needs. To tempt him with the possibility of avoiding all frustrations by freely absenting himself is now undesirable. Running away, of course, still seems the easier way out of the conflict. But it also deprives the child of the presence of the adult who could now help him to withstand tension because he has learned to enjoy the association of protecting adults. Running away also exposes the child to new temptations which he may not yet be able to withstand. Finally it increases his guilt and thus interferes with his relationship to the adult. This is the stage at which the child should rightly expect the latter to protect him through restraint from the damaging results of his asocial tendencies. Moreover, due to the development of an overstrong superego which characterizes the stage in which an acting-out delinquent changes into a neurotic delinquent, the child has a tendency to self punishment which may reach degrees actually endangering his life, or bring him into such serious conflicts with society that the therapeutic progress is materially handicapped by his living in a strictly open institution.

In some cases, psychological developments which could have been telescoped into a few months, had a therapeutic closed institution been available, actually took close to a year since they had to proceed in a world full

of temptation to act out which an open institution affords. In other cases, children were ready to exchange violent acting-out for equally violent self-destructive behavior. Since an open institution could provide no adequate protection from the latter, the treatment processes had to be slowed down to prevent self-punitive tendencies from reaching dangerous proportions. In general, it may be said that while present practice is to put acting-out children in closed institutions and to keep children with self-punitive tendencies in the community, the reverse is therapeutically indicated—that is, to keep acting-out children in open institutions where therapeutic relationships can be established on the basis of the institution's greater permissiveness. Relationships thus formed must later be used in order to fortify superego controls, which in their initial stage need the added protection against temptation provided only in the closed institution, while in the latter stages, as already pointed out, only the closed institution provides the necessary protection against self-destructive tendencies. The acting-out delinquent who is immediately placed in a closed institution is usually unable to form therapeutic relationships to staff members because of the, to him, insufferable restrictions placed upon him by the institution of which the therapist is a member. An example of this need for combined treatment in open and closed institutions may illustrate the problem.

A seven year old boy whose traumatization originated in the abuses, mistreatment and destructive excesses of his alcoholic father, had to assure himself of his ability to escape threatening and overwhelming situations at any time by constant running away. In order to manage his fear of his father, he had also to prove to himself that he could successfully intimidate others by his aggressive behavior. If this child had immediately been placed in a closed institution, without the freedom to run away from events which had once been real and had still the powerful force of strong fantasies, it would have meant exposing him to situations in which he was forced to explosive behavior. It would have created such bad relationships to staff members that the formation of protective ties would have been impossible.

In an open institution, he could freely demonstrate to himself his ability to escape from imaginary dangers and this provided him with a much needed motor discharge of tensions. In order to establish a therapeutic relationship with him, a counselor accompanied him as far as possible on his truancies, and was thus able to establish a relationship. Once this contact had been established, the boy began to feel guilty about running away and because of his guilt, committed frequent self-endangering acts while playing truant. He frequently criticized the institution for not putting more restraint on him and specifically asked that the doors be locked so that he could not run away even if he wished. The continued possibility of running away which had first provided the necessary security for forming a relationship, now became a threat to further personality integration. If, at this period, the boy could have been placed in a closed institution offering the same therapeutic relationships and abundant gratification of instinctual needs, the integrative processes which in the open institution took almost a year's time, might have been achieved in a few months. During this period, his truancy created such guilt feelings that the boy denied himself the gratifications which he very much needed. This was the moment when institu-

tional restrictions should have supported the tendencies of his superego, which were still very weak and very critical. Guilt over his truancy also increased his ambivalence toward his counselor, despite her assurance that she was not annoyed. After the boy's superego had developed the necessary strength for exercising restraint and had at the same time become less critical, the advantages of an open institution for his reintroduction into society became obvious.

Similar observations were made in the case of another delinquent child whose presenting symptom was stealing. He soon learned to restrain his desire to take things from those he knew, namely, the staff and other children living in the institution who had become important persons to him. At the same time, he was unable to restrain himself from taking things on the street or from persons who were not connected with the institution. Because of his warm relationship to members of the institution, he felt tremendous guilt about stealing and revealed it in self-punitive tendencies. Whereas he was able to withstand the temptation of money or desired objects when they were connected with meaningful persons, the temptation was greater than the restraining forces if such a connection failed to exist. During this particular period of development, this boy's progress too would have been greatly enhanced by temporary placement in a closed institution.

In this connection, one may also note that the charm and appeal of very young delinquents is often catered to by passers-by who encourage their delinquent behavior. Other children use such support for their neurotic tendencies in casual acquaintances struck up on the street, contacts which cannot be controlled in an open institution.

These examples may demonstrate the obvious protective values of a closed institution. Equally important, though less dramatically visible, are the intangible protective qualities of a good closed institution. Nearly all children, upon entering the institution, show great anxiety about whether restrictions are imposed on their freedom. They derive great security from the visible demonstration that all doors are always unlocked. Fairly soon, the satisfaction about the open doors turns into anxiety because they realize that open doors are two-way connections and while they permit ready egress for them, they begin to fear that they may permit the entrance of figures which used to threaten them in the past. Gratification which the institution offers and which is therapeutically indicated is shunned because of the fear that parents may suddenly enter and discover that they enjoy pleasures of which the parents had disapproved. The children ask for frequent reassurance that parents will not interfere with their lives in the institution. This reassurance is not easily effected in an open institution.

A twelve year old boy, whose bad experiences in school had led him to fear the classroom situation, was encouraged not to attend class for some time but to play in the yard or in the dormitory. This was to help him grow secure in the less threatening environment before introducing him into the phobically cathexed classroom. He was unable to accept this offer because of his fear of truant officers. He would not believe the assurance that truant officers were not permitted to enter the institution and as an argument for the reality of his fear he used the fact that the

doors were always open and that therefore anybody, including the feared truant officer, might enter at any time.

In conclusion, an example might be given of the way one child verbalized these and similar emotional conflicts: Preceding the incident, he had twice been picked up by the police for stealing and destroying property and had temporarily been placed in a detention home. This boy had virtually discontinued his delinquent behavior within the institution and particularly in the presence of the counselor to whom he had formed a strong attachment. One day, in a session with his counselor, he was playing with clay. He suddenly laughed, and when asked what was so funny, he said, "I was thinking of high prancing low horses. You see, they're really awfully low but they don't want strangers to know that, so they just prance high. But if they couldn't prance high then they wouldn't get into trouble and would lay low all the time." He was one of the boys whom strangers always egged on to "prance high" although through therapeutic progress, he had reached a stage where he really, wanted to "lay low" for a long time.

Society, which professes concern for its emotionally disturbed children still offers only settings which present unmanageable temptations or which are of a punitive character. Frequently, what are really needed are settings which combine ample gratification with adequate protection against unintegrated id drives and societal temptation, settings in which protection is not identified with restraint and which are free of all punitive tendencies.

Thus the controversy over whether institutions should be open or closed resolves itself: we need both open and closed institutions but only if they are organized and function on the basis of sound psychotherapeutic principles.

A CASE OF ANXIETY NEUROSIS IN A SMALL CHILD

By NIC WAAL, M.D.

Thirteen years ago in Norway I was asked to see a four and a half year old girl who had undergone a startling and complete personality change during the previous year. The case was interesting to me because it demonstrated the fears, anxiety and misapprehension which small children can develop even in an enlightened home environment, and also because it illustrated the reversibility of quite serious behavior disturbances in children.

The patient was reported by her parents to have been a very active, alert, happy child until she was three and a half years old when she refused to go to nursery school, which she had previously been very fond of, and clung desperately to her mother all day long. She cried frequently and had temper tantrums whenever the mother had to leave her, refused to be taken care of by anyone but the mother, stopped playing and going out with other children, showed a fear of many sounds such as the radio or phonograph playing, and was so terrified of thunder that she would cry all day whenever the sky was cloudy, apparently afraid it would break into thunder. She was also afraid of the dark and had many night terrors which caused her to refuse to sleep alone.

A pediatrician whom the child's mother consulted had tried to get the mother to force the child to attend nursery school and to play with other children but the mother had feared to do so and had decided to come to a psychiatrist. She had previously tried humoring the child in the hope that the fears would disappear, and, in fact, her physician had told her that children usually outgrew such troubles. The child, however, had grown worse and worse until the mother was totally enslaved and had had to give up the part-time secretarial and administrative work which she had done for her husband since her marriage.

The child was extraordinarily beautiful, but quite pale and passive. She had golden curls, a sweet smile and an extraordinarily rich vocabulary, too sophisticated for her age.

I told the mother that the treatment would probably take a long time but that I would agree to see the child for three weeks of observation before giving an opinion. As it turned out, I saw the child for a period of from an hour to an hour and a half, nine times during the next three weeks, after which she was completely recovered and has remained so until the present time. She became a strong, lively, daring child who went through puberty without any kind of disturbance and finished preparatory school (the equivalent of two years of college) with superior grades.

Family History

There was no history of disease in the parental family which was of sound rural ancestry. The father, a college teacher in his forties, was a progressive and liberal man. He was fond of children, but was a rather dry intellectual type who did much overtime work and had never participated in the care of the children except during the holidays when he devoted himself to them. He did not favor any one of his children but spent more time with the older girls because he understood better how to teach them. The patient was therefore too young to share his companionship. Reared very religiously, he was no longer religious himself, but retained a somewhat moralistic view which was in contrast to his modern psychological opinions about child development.

The mother, forty, was a very beautiful, blond, gracious woman, intelligent and understanding but with a tendency to hysteria. She was the only child in a well-to-do radical family of university professors. She had a masters degree in language and philosophy and had been a teacher in high school where she met her husband. They had been married twelve years and according to the wife had been very happy. She gave up her career with her first pregnancy, but she worked part-time as her husband's secretary in school administration and assisted him in his studies.

The first birth was a caesarian. The next birth, four years previous to the patient's, was a very hard one, in which the mother nearly died. Both these children were girls. After several artificial abortions, she gave birth to a boy who died during labor. Both parents had wished ardently for a boy and the mother was very depressed for a while. In a year she was pregnant again and, although they had hoped for a boy, they were not disturbed for long when a girl child was born, as she was such a loving, charming creature.

The mother admitted that although she enjoyed intercourse and both parents were quite happy in their marital life, she was afraid now of becoming pregnant and very seldom had an orgasm. To avoid pregnancy they had practiced interrupted intercourse, but as one physician had said it was damaging to the nerves, the husband now used contraceptives which she despised. But in spite of knowing about pessaries, she was too shy to try to learn their use.

This shyness she demonstrated in a hidden way. She seemed to talk very freely about sexual matters but blushed when talking about giving the children sexual information. She was also quite indignant and embarrassed when she told about the children using dirty words, but tried to speak in a modern tone about the matter. The role of the father in impregnation had not been explained to the children but all other questions had been answered. The patient had never asked any questions. The mother was sure she knew all about sex because she had seen animals in the country and watched calves being born. None of the children had been interested in sex differences but the mother thought that was because there were no boys in the family.

Developmental History

The patient's birth was normal. She took the breast very well, but because of decreased milk, she was given an additional bottle from her second month and had mixed feedings for five months and then was weaned without difficulty to a cup. The feeding was strictly scheduled but the child showed no signs of disturbance. She was toilet trained very early, starting from the second month, and was put on a training seat from the fourth month on, but accepted it freely and happily. She was bowel trained at one year but wet herself in the daytime until she was two and a half and infrequently at night until the time I saw her.

She walked and talked at one year of age and talked perfectly in sentences without any baby talk when she was two. On the whole, she was an extraordinarily harmonious child, always beaming with laughter and fun. She was active but not disturbing and seemed to know always what she wished to do.

The children were allowed much more freedom than the neighbor children and consequently the house was always full of playmates. The parents felt a little concern about the neighbors' criticism of their methods but they tried not to be influenced and to maintain their own ideal.

The patient started to nursery school when she was two and a half. She enjoyed it and was exceptionally gifted in drawing and painting. She slept in the parents' bedroom until she was three and a half but did not seem to react to being moved to the sister's room then.

Some months after this during the summer holidays, the child began to alter her attitude. It seemed as if she had had some shock, but the parents did not know of any. In the beginning the symptoms were fear of dogs, thunder and the dark. In the autumn she refused completely to attend nursery school, reacted badly to sounds, shunned other children's company and for the rest of the year clung to her mother and gave up all activity.

First Interview: In the first interview she did not show the extreme passivity which the mother described. As soon as she was inside the treatment room she threw herself on the typewriter, then sprang to the phone and dialed some numbers. She was seemingly very free and grown up, but something in her attitude denied this. She was a little too sweet and coquettish, a little too restless. If her mother moved, she sprang forward and clung to her and when her mother moved to the door to go, she cried to go with her.

I decided to let the mother stay and began to play with some toys. The child was seemingly interested but refused to paint. She observed me passively while keeping one eye on her mother. It struck me that she had awkward, stiff shoulders and a distinct weakness about the whole figure. Her breathing was very superficial and her hands were passive and babylike.

She begged me to draw a portrait of her, which I did. I had noticed previously that she typed only girls' names on the typewriter and when I asked for the father's name she said she had forgotten it and stopped typing. I now tried an experiment and drew a picture of the father smiling. At this point she left the table and clung to her mother again. I agreed with the mother that both should leave and come again for another appointment.

Second Interview: At the next appointment, when the mother left, the child tried frantically to dash out of the door, which had to be shut. She threw herself on the floor in a temper tantrum, striking the floor with her hands and feet. After a few minutes the screaming changed to loud weeping and she peeped sideways at me.

I played with the toys without saying anything. When her weeping

became very forced and her interest was growing, I showed her an alarm clock and said that in an hour the clock would ring and then she would find her mother sitting in the waiting room. She refused to believe me at first and then asked if the clock could ring sooner. I explained that we could make the clock ring at any time we decided, but the mother would not return until one hour had passed.

After I had shown her how the alarm clock worked I asked her if she would like to draw or paint. "No", she said, "I don't like to draw trolls". I told her that I did not believe in trolls. She said she did and that her nurse had told her the trolls were cross if she was not a good girl and that she (the nurse) would not come back if she was not a good girl. "Dadda (nurse) also says Mommy won't come back if I am a bad girl".

We talked about her mother helping her father with his work so that he could have more time to play with the children, and how both parents would always come back. I said that nurses sometimes did not know what to say when she made a fuss and therefore invented silly things and did not realize that she really believed them. Turi looked relieved, interested, but very dubious. She began to be restless and to watch the door and to ask when the clock would ring.

While exploring the material she saw a steam engine and wanted to see it move. We started it but when the engine began to whistle she looked horrified, turned pale and began to weep. I stopped the engine, showed her the interior and explained the mechanism. I told her that we are afraid of things many times because we do not understand them and feel insecure—but when someone explains them, the fear disappears. She tried again to play but each time she touched a toy she stiffened her shoulders and held her breath. Since this was so noticeable, I asked her if she knew the breathing game. I showed her how big the stomach is when a breath is taken and how small it is when breath is expelled, like a balloon being blown up and then deflated. She lay down on the couch with her shoulders stiffly drawn up. I loosened the shoulders playfully. She started to breathe as I did and began suddenly to laugh loudly in a way quite unlike her usual attitude.

When the clock rang she was quite uninterested and was reluctant to leave when her mother knocked at the door. She exclaimed she would like to come the next day and that her mother could work with daddy and let her nurse come with her.

Third Interview: From then on Turi came with the nurse. She said she was playing being a very sweet little princess going to her aunt and her appealing and oversweet manner bore this out. She cried crocodile tears when the nurse left but proposed at once that we play breathing, "to fill the balloon" as she called it.

After a little while she laughed again loudly, sprang up and said, "It tickles, now I will paint". In a few minutes she had painted a house which looked more like an animal except that there was a realistic chimney on the back of the figure with brown smoke streaming out. She told me, "This is a house with beautiful things and a brown toilet! Have you seen brown smoke? It can also be brown dirt and it can be father and mother and also Kari (the sister) and a baby."

I asked where the baby was in the picture but she would not answer; instead she exclaimed, "Think of that. Kari calls the 'great mass' (faeces), 'tupp-tupp' (chicken)", and without any pause continued, "The baby comes from England—but I don't know, I . . ." After this hurried exclamation she would not talk any more, would not listen to me and was very restless. The drawing seemed to be a quite complicated symbolization, a variation of normal children's use of a house as a symbol for human beings. Her house looked like a dog and recalled her fear of dogs. The inside of the house was full of confused figures, and there was a toilet (which normal children seldom draw so early in a series of drawings).

Her words were rich in symbols: faeces were called "*stor mass*" which means great masses. "Mass" is also a Norwegian man's name. The sister's word, "tupp-tupp" is sometimes used by small boys for the penis and sometimes by adults for the female sex organ. In the same breath she said that the house could be her father and mother, herself, her sister and a baby and denied in the next moment her betrayal of unconscious ideas and repeated some adults' stories about babies coming from England. (This is a popular substitute for the stork story in Norway.) She then admitted she did not know where babies came from. After finishing the drawing and her comments, she was pale and fatigued, and showed the blocking and typical denial of repressed anxiety. Since she covered her ears with her hands I could not point out to her her resistance or anxiety, and the interview was finished.

Fourth Interview: Turi was very restless and skipped from one thing to another. It was impossible to involve her in any play for more than a few seconds. I told her she had been frightened by her drawing at the previous interview but she denied this and closed her ears with her hands again. She refused to lie down on the couch.

I turned on the radio and began the breathing play with hopping and dancing. She hesitated but got interested and followed me, copying my movements. After a while she looked relieved and proposed that she paint. She painted the whole sheet evenly red, then smeared brown all over (which indicated the repression, denial and anal regression). When I asked her if I should tell her what I thought, she answered, "I will ask mother", in a reluctant and fearful voice. She threw herself on a toy, then suddenly

begged me to show her the steam engine, but not to let it move. Her pupils were dilated, her face pale and her shoulders were again stiff and hunched. I pointed out that she was afraid. She at first denied then admitted it. Again I showed her the inside of the engine and told her what made the steam come out. At that she asked, "Can you tell me everything, can you?" I said that I did not know everything in the world, but I thought I did know most of the things she feared and could explain them to her.

"But then you will tell me only absolutely true things if I ask?"

I told her I never lied to children, because I knew they would be happy only when they felt they could rely on the honesty of adults. "Oh, they are so silly when they lie", she exclaimed, beaming. "Now I will ask!" But before coming to the question she got pale again and asked instead, "Is someone up there?" and pointed to the ceiling. I said no. "I heard someone walking upstairs", she said anxiously and looked dubious when I repeated that it was impossible since it was a one-story house. Unconvinced, she said, "Mommy also says so when I hear someone in the night" (thus telling me about her night fears). Walking to the door, she then said with a half-smile, "I will ask you the next time."

Fifth Interview: The next hour she ran without suggestion to the couch and began breathing. Then she dashed to the painting table and painted a house with a baby attached, "That's the house and the brown is 'mass' and also the baby." When I asked why the baby sat on the house in this way she exclaimed earnestly, "Kari says the baby is in mother's stomach, Dadda (nurse) says it comes from England and so does Betsy (a friend)". After this explanation she said with a hesitating but somewhat coquettish smile, "Tell it to me then!" (She thus indicated her confusion in the common symbolization of *faeces=baby*, and, in the drawing with the baby protruding out of the house-body, she also symbolized baby=penis.) I did not interpret this but gave her a simple explanation of pregnancy, birth and sex differences. She was very happy and left jauntily.

Sixth Interview: The nurse said that Turi was very altered, very easy to handle. The only symptom left was a certain sensitivity to sounds.

Turi again started breathing but showed uneasiness and said it tickled. She went to the painting table, and painted a sheet brown with a red quadrant. Pointing to the red spot, she said, "It's blood, it's the door after the baby came out", she would not talk any more but asked me to "burn the steam engine". She looked a little afraid when the fire flared up in the beginning, but soon quieted down. Looking at her drawing, I asked why the house was brown. She said, "The baby comes with the mass." I explained the digestive system and told her the baby had its own place where it was warm and nice and then I asked her why the door was red. "Oh, it bleeds terribly, Mommy has blood there," pointing to her genitalia.

Realizing that she had happened to see her mother during menstruation, I said it did not hurt, and explained how the heart pumped blood to the "nest" so that the baby got food. When there was no baby in the "nest" there was too much blood, and it simply ran out of the door. I repeated that it did not hurt. She left very peacefully.

Seventh Interview: Turi said that she did not like to breathe and started at once painting a house. The fifth drawing was a total anal regression expressed in brown and black paint. She asked me to explain how the baby came out again and I told her about birth and explained that there were separate passages and openings for the baby and for urine and for faeces. "But can't boys get babies then?", she asked. I repeated my explanation of sex differences and the function of the semen as being like seed which we plant in the earth. She seemed happy and asked me to draw a nude boy and a nude girl. When I finished she would not look at the boy and said reluctantly, "Boys are bad—they hurt." I asked which boy hurt her. "Walter and Erling. They run into you with the bike, they put sticks in your stomach and try to peek at you on the toilet." Then she told me about her boyfriend, Walter. She feared him although she liked him very much. (Before the next interview I asked the mother about Walter and Erling. The mother said that they were friends until Turi drew away from all comrades. These boys were quite daring and aggressive and the mother believed they were involved in some sex play but they loved Turi and asked for her each day and had been very sad when Turi refused to go out. About the same time that Turi moved out of the parents' bedroom, Walter actually ran into Turi with his bicycle. She was not hurt but she screamed terribly and he was very contrite.)

Eighth Interview: Turi again started by painting a house with decorations. She poured out sentences explaining the drawing, "This is a house and also a stomach. There are many peep-peeps [small birds] in it and a lady who embraces a man and someone sails a boat and the lady does this with her legs". Turi now lay down and opened her thighs and legs. Then she said, beaming, "That is Mommy, Daddy and Turi, Walter and Erling—you shall write it all down, write!" She eagerly watched me writing, pointing to the drawing to illustrate her story. Then she looked searchingly at me, saying, "Daddy hurts Mommy in the dark." I asked, "What are they doing in the dark?" She replied, "They are loving each other—I heard them and Mommy whined!" I reminded her of her night fears and said that since it was dark, she could not see anything, and she believed mother whined, but actually mother was happy. I explained that people loving each other were happy and played and sometimes made sounds, but since children were not supposed to know what was going on and did not get any explanation, they became afraid and felt guilty. I also said I believed

Walter loved her, but since he did not know any more than she, he also was afraid. He liked to caress her but believed he should boast and show how daring he was and so was a little too rough with her. I believed that if she did not fear him, now that she understood things better, she could explain them to him. Then he also would understand that adults who loved each other, did not hurt each other. If he tried to strike her, why didn't she strike back? She said, a little unhappily, "Boys are so much stronger". I said, yes, sometimes, but girls could be very strong too if they had no fears.

She became very lively, dashing about, displaying a lot of aggression. Before she went away she painted an ordinary realistic house, and said, "This is a house with a road and a green garden".

Ninth Interview: The next hour Turi was easy, singing, and playing. Then she wished to breathe. When she said it tickled, I told her that many children liked that sort of tickling. She laughed and looked curiously at me saying, "Kari said it was dangerous." I asked *what* was dangerous and she replied, when someone, Walter for instance, tickled her or when she tickled herself on the peep-peep. I understood that she meant masturbation, so I explained that many children tickled themselves on the peep-peep, that it was because one was alive and grew and felt good in the body—that it was quite all right. She jumped up, laughed loudly, put on records and sang loudly, "I am also alive, I am also alive." She beamed happily when she left.

The school holidays were coming and the mother asked for some advice. I told her to learn to use a pessary as a contraceptive device. The father was advised to alter his demeanor and try to play more with Turi and the mother was to talk with Kari about masturbation. We agreed that Turi should come back after the holidays.

When the time came, the mother phoned me and said that Turi did not show any signs of fear, slept and ate well, played with the boys and liked dogs. She was also physically changed, had become strong and outgoing and was unusually lively. She had returned to kindergarten and was doing well.

When Turi visited me a year later, she smiled and remembered me, but was normally uninterested in me. Physically she was so altered that I barely recognized her. She was now rather big for her age, sound, strong, and free in her movements, with no hint of the pale, oversweet princess. Twelve years later, before leaving Norway in 1947, I learned that she had gone through high school with superior grades and intended to go to college and that she was popular with both boys and girls.

Discussion

The Diagnosis: This child showed withdrawal, passivity, narcissistic tyranny, acute anxiety, and character-alteration, with vague symptoms of illusions. Some child psychiatrists would be tempted to call her a severely disturbed psychotic. The harmonious development and the cure after short psychotherapy in this case makes the diagnosis, *acute anxiety state* with development in the direction of severe maladjustment, preferable.

Treatment: The therapeutic method was an elastic use of psychoanalytic play therapy combined with the use of respiration, muscular relaxation and musical rhythmical movements. This technique, supplementing the play therapy, was a new technical measure in the author's methodology, suggested by the "vegetotherapy" with adults described by Dr. Wilhelm Reich. It seems to the author, from experience, to be valid with children in this age group.

The therapeutic process was characterized by practically no interpretation of symbols, as the child gave the interpretations herself. The experience of the author shows that this is typical of children younger than five and six years of age. The reality and the phantasy, that is the symbolization of conflicts, seem much closer before the latency period than later. It seems as if the symbolic language is understood by the child, himself, which would indicate that, without the strong ego and superego defense of later years, the child has access to both conscious and unconscious material almost simultaneously.

Conclusion

This case is also interesting from the point of view of mental hygiene and preventive medicine. I would advise against a too optimistic belief in the intellectual freedom of modern parents in child education, even though intellectual understanding is better than none. As to preventive medicine, we may learn from this and other such cases that psychotherapeutic measures taken at the acute onset of childhood neurosis are very promising as a means of preventing neurosis in later life. The expense of mental hygiene work for preschool children may spare society far greater expense for mental illness in adult years.

BOOK NOTICES

Sexual Behavior in the Human Male. By ALFRED KINSEY, WARDELL POMEROY AND CLYDE MARTIN. Price $6.50. Pp. 765. Philadelphia, W. B. Saunders Co., 1948.

This book will undoubtedly be a landmark in medical history, partly for the implications of its content and partly for the courageous originality and vision of its scope. The brief preface by Alan Gregg is an eloquent classic of scientific credo. (Karl Menninger, M.D.)

Handbook of Psychiatry. By WINIFRED OVERHOLSER AND WINIFRED V. RICHMOND. Price $4.00. Pp. 252. Philadelphia, J. B. Lippincott, 1947.

There has long been a need for such a book to provide accurate and intelligible information concerning mental diseases to the lay public. It is simply written and amazingly free of the technical language which is part of our professional jargon. The treatment of some subjects is too brief to be worthwhile, as in the case of the formulation of psychoanalytic theories. Particularly well handled is the treatment of popular fallacies regarding mental disease, the modern mental hospital and modern methods of treatment. It is not likely that this book will reach the general public itself despite the obvious need for such a work. However, it should prove valuable to those individuals who must answer the layman's questions regarding mental disease and psychiatry. It is highly recommended for its presentation of the facts in a non-technical and very readable, though sometimes sketchy, manner. (Irving Kartus, M.D.)

NOTICE

A master index covering the first eleven years of publication of the *Bulletin of the Menninger Clinic* has just been published and is available at fifty cents a copy. Address the *Bulletin of the Menninger Clinic*, Topeka, Kansas.